Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-8151-01

MFDR Date Received
AUGUST 21, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the hospital's position that the patient required emergency medical treatment to resolve his complicated medical condition. Because there is no certainty or predictability as to what a patient's needs will be in any given emergency admit, the cost of providing necessary care and treatment cannot be predicted with any degree of certainty."

Amount in Dispute: $29,199.90*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is seeking additional reimbursement for services between August 28, 2006 and August 30, 2006. The carrier would point out some errors on the provider's part. First, the provider on its Table of Disputed Services identified the total payments made by the carrier as $2245.10. That is incorrect. Rather, the total amount of reimbursement is $4,481.00. This is based upon an initial EOR that recommended reimbursement of $2,236.00. That represents reimbursement for a two-day stay for surgical treatment. In the response to the provider's request for reconsideration, the carrier provided additional reimbursement, the carrier provided additional reimbursement in the sum of $2,245.10. I am attaching a copy of the carrier's EOR dated November 29, 2006. The second reimbursement was for supplies and implants. One of the provider's documents attached to its DWC-60 was a letter from its counsel dated July 18, 2007. In that letter, the provider took the position that there was no established fee guideline under the acute care inpatient hospital fee guideline. Instead, the provider claimed that the reimbursement should be fair and reasonable. However, there is an acute care inpatient hospital fee guideline. See Rule 134.401. The carrier's reimbursement on its EORs is based upon Rule 134.401(c)(1) and 134.401(c)(4). The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2006 through August 30, 2006	Inpatient Services	$29,199.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement. National Healthcare Alliance.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 147 – Provider contract/negotiated rate expired or not on file.
   - W3 – Additional payment made on appeal/reconsideration.
   - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 426-Reimbursed to fair and reasonable.
   - 718-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility, additional payment may be considered if data is submitted.

Findings

1. * The requestor submitted an updated table December 2, 2008 showing the respondent made an additional payment.
2. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contract/legislated fee arrangement. National Health care Alliance" and 45 – "Charges exceed your contracted/legislated fee arrangements." Review of the submitted information finds the respondent did not maintain this denial upon reconsideration. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 812.41. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute

involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor seeks full reimbursement of billed charges based upon "It is the hospital's position that the patient required emergency medical treatment to resolve his complicated medical condition. Because there is no certainty or predictability as to what a patient's needs will be in any given emergency admit, the cost of providing necessary care and treatment cannot be predicted with any degree of certainty."
- The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		November 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		November 29, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.